would argue that such a life expectancy is certainly long enough not to simply disregard the radiocephalic fistula.

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Regarding "Stenting for femoropopliteal lesions"

We have read with interest the article by Mwipatayi et al[1] on the contemporary topic of femoropopliteal stenting. Unfortunately, the authors' conclusion that stent placement for treatment of femoropopliteal disease does not increase patency at 1 year compared with balloon angioplasty alone is flawed by several unacceptable limitations of this meta-analysis.

Clinical heterogeneity of the included studies is the most relevant drawback: First, different types of stents (balloon-expanding stainless steel stents, self-expanding Elgiloy stents, self-expanding Nitinol stents, and polytetrafluoroethylene-covered stent grafts) were included in the analysis. Each of these devices has fundamentally differential characteristics, indications, and outcomes, and therefore cannot be summarized as one category.[2] Second, seven prospective randomized studies were mixed with the results of a retrospective and purely observational study. Particularly, the latter study was of extremely poor quality without standardized follow-up intervals (follow-up ranged from 1 to 72 months). Third, clinical characteristics of patients treated within the studies were highly variable: Balloon-expanding stents can be used for only very short lesions (spot stenting), whereas stent grafts and self-expanding stents are implanted for longer lesions. Because of this selection bias, it is impossible to assess whether stents may have beneficial effects in certain predefined subgroups (eg, patients with long lesions or total occlusions). Fourth, treatment strategies within the different trials were not consistent: six randomized studies including short lesions compared primary stenting vs balloon angioplasty alone. In contrast, one study that also included longer lesions compared primary stenting vs balloon angioplasty with optional secondary stenting.[3]

In Table 1 restenosis and patency rates of the ABSOLUTE trial[3] at 12 months are mixed up (the table reports 63% patency rate, which should read 37%). This overestimation may have significantly influenced the pooled risk estimates.

Addressing the issue of stent fractures, six of the eight studies did not systematically assess stent fractures; therefore, this end point should not be reported.

Finally, a cut off for including studies published later than the year 2000 is by no scientific means justified. A major change in stent technology was seen in 2004 and 2005 when the first promising data on Nitinol stents were reported. From our point of view, a clinically reasonable meta-analysis should include only data from randomized controlled trials comparing Nitinol stents vs balloon angioplasty, that is, findings from the ABSOLUTE,[3] FAST,[4] and RESILIENT trials.

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Reply

The drawbacks of our study were addressed in the discussion portion of our paper.

1. We were unable to acquire missing data from the authors of included studies. The clinical heterogeneity of the included studies was a relevant drawback because those studies were conducted by different authors; these authors may not have included data according to the Society for Vascular Surgery/International Society for Cardiovascular Surgery (SVS/ISCS) standard of reporting, thus affecting the results of the meta-analysis.
2. A sensitivity analysis was performed that excluded studies that might influence the final result. It did not change the findings of our meta-analysis.
3. In the Design/Methods section of our paper, we clearly defined re-stenosis and primary patency. Re-stenosis and patency rates were not mixed in Table 1. Unfortunately, reporting inconsistencies occurred in all studies. Some authors included restenosis rate and others reported primary patency.
4. We agree that the issue of stent fractures cannot be reported as an end point: We did, however, include the results of the few studies that reported stent fractures because we have reported our own experience in another area (carotid stenting).
5. Data for this study were collected from September 2000 and January 2007, and Absolute and Fast were included. The Resilient results were not available at that time. We were amenable to the inclusion of studies that did use new stent technology.